U.S. Department of Labor

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IN THE MATTER OF:

MARTIN SOMMER
Claimant,

v. Case No.: 1999-BLA-00369

PEABODY COAL COMPANY
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

DECISION AND ORDER ON REMAND - AWARDING BENEFITS

This case arises from a claim for federal benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 et seq. ("Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718, and 727 ("Regulations").

The Act and Regulations provide compensation and other benefits to: (1) living coal miners who are totally disabled due to pneumoconiosis and their dependents; (2) surviving dependents of coal miners whose death was due to pneumoconiosis; and (3) surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. See § 718.201.

Statement of the Case

A Decision and Order Awarding Living Miner's Benefits was issued by the undersigned Administrative Law Judge on September 17, 1999, finding that Martin Sommer ("claimant") was totally disabled due to pneumoconiosis. The claim was adjudicated under the regulations at 20 C.F.R. Part

718. Employer, Peabody Coal Company, appealed the decision to the Benefits Review Board ("Board"). The Board issued a Decision and Order on December 18, 2000[1] affirming in part and vacating in part the decision awarding benefits, and remanding the matter for further consideration consistent with its opinion.

The Decision and Order issued by the undersigned Administrative Law Judge on September 17, 1999 found that claimant was totally disabled from pneumoconiosis caused by his years of coal mine employment. The Board found error in: the refusal to admit documents into record from claimant's state worker's compensation claim; the finding that the claimant established the existence of pneumoconiosis pursuant to § 718.202(a)(1) and (a)(4); the finding that claimant's totally disabling respiratory impairment is due to pneumoconiosis pursuant to § 718.204(b); and the determination of the date of onset of disability.

Findings of Fact and Conclusions of Law

Except as modified or superseded herein, the Findings of Fact and Conclusions of Law set forth in the September 17, 1999 Decision and Order are incorporated herein.

State Worker's Compensation Documents

At the hearing the employer offered into evidence documents marked as Employer's Exhibits 16-19 which are part of a claim filed with the Illinois Industrial Commission asserting traumatic knee injuries. Employer argued that the documents were relevant to this proceeding because if the claimant was adjudicated as totally disabled from a knee injury he could not be considered as eligible for black lung benefits because of a subsequent pulmonary disability. As support, employer relied on the 7th Circuit Court decision in *Peabody Coal Co. v. Vigna*, 22 F. 3d 1388, (7th Cir. 1994). However, since the Order of Remand, the Department of Labor has promulgated amendments to the regulations governing the award of benefits from pneumoconiosis which in effect abrogate the Court's decision in *Peabody*. Those amendments preclude the consideration of any nonpulmonary condition unrelated to the miner's pulmonary disability from being considered in determining whether a miner is totally disabled from pneumoconiosis. See§ 718.204(a).

The Board's remand to consider the Illinois Industrial Commission claim records was also

[1]Although the BRB issued its decision on December 18, 2000, it did not return the record to the Office of Administrative Law Judges until February 15, 2001.

based on employer's argument to the Board that the documents constitute relevant evidence of the absence of pneumoconiosis because they include negative chest x-ray interpretations. Employer never made such an argument while the matter was before the Office of Administrative Law Judge. *See* Transcript of Hearing, pp. 52-59

After considering the documents marked as Employer's Exhibits 16-19, it is determined that they deserve no weight. Chest x-rays taken on March 7, 1986, July 14, 1986, December 8, 1987, August 8, 1988 and March 1, 1991 were not interpreted for the presence of pneumoconiosis. X-rays taken on August 22, 1988 and June 24, 1991 were read as evidencing chronic obstructive lung disease.

Existence of Pneumoconiosis pursuant to Section 718.202(a)(1)

The record contains forty-two interpretations of five x-rays. The Board sustained the methodology used in considering whether they established the existence of pneumoconiosis. Nevertheless, the Board found that the x-ray evidence again must be weighed because the undersigned's evidentiary review failed to consider an interpretation by Dr. Stuart S. Sagel and the previously mentioned x-rays that are included in the Illinois Industrial Commission claim records.

The review of the five x-rays of record revealed that only those readings associated with the April 3, 1998 x-ray support a finding that claimant does not have pneumoconiosis, whereas the interpretations of the x-rays taken on August 1, 1989 and June 24, 1998 evidence the presence of pneumoconiosis. The x-ray taken on October 21, 1997 was accorded little weight because it was labeled as unreadable by three physicians qualified as B-readers and Board Certified Radiologists. The readings of the remaining x-ray taken on November 5, 1991 were considered as equivocal and thus not probative as one reading was positive by a physician qualified as a B-reader and Board Certified Radiologist and the other was read as negative by a different physician but with the same qualifications. The reading by Dr. Sagel of the November 5, 1991 x-ray is in narrative form, stating in part, "no radiographic evidence of pneumoconiosis seen." Dr. Sagel's qualification's are not of record; thus his reading cannot be given greater weight than the reading by Dr. Marshall, the Board Certified Radiologist and B-reader who read the same x-ray as positive. Accordingly, the reading by Dr. Sagel does not affect the finding in the September 17, 1999 Decision and Order that the November 5, 1991 was equivocal as to the existence of pneumoconiosis, and therefore does not affect the finding therein that the preponderance of the x-ray evidence is positive for pneumoconiosis.

The chest x-rays that were included with the Illinois Industrial Commission records were not read for the presence or absence of pneumoconiosis and therefore are not probative for the existence of the disease, particularly in light of the large number of readings made specifically to detect the disease.

Accordingly, as found in the September 17, 1999 Decision and Order, the x-ray interpretations establish the existence of pneumoconiosis.

Existence of Pneumoconiosis pursuant to Section 718.202(a)(4)

The September 17, 1999 Decision and Order determined that pneumoconiosis was established by the weight of the medical opinion evidence pursuant to § 718.202(a)(4). More weight was given to the opinions of Drs. Houser and Cohen than to the opinions of Drs. Tuteur, Hippensteel and Renn. One of the grounds given for assessing greater weight to the reports of Drs. Houser and Cohen was that their opinions were better supported by the x-ray evidence. However, the Board vacated the finding in light of its holding, previously discussed herein, that the analysis of the x-ray evidence was flawed. Since the re-evaluation of the x-rays of record finds that they establish the existence of pneumoconiosis, it is again determined that the opinions of Drs. Houser and Cohen are entitled to greater weight since they are better supported by the x-ray evidence.

The medical opinion evidence also shows that the claimant has legal pneumoconiosis by establishing that claimant's chronic obstructive pulmonary disease is caused by his coal dust exposure. Chronic obstructive pulmonary disease, asthma, and bronchitis fall under the definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 BLR 1-798 (1981). Seven physicians offered opinions relevant to whether claimant has legal pneumoconiosis, Drs. Houser, Eisenstein, Cohen, Kelly, Renn, Hippensteel and Tuteur.[2]

Dr. Houser is a pulmonary specialist who is certified in internal medicine and pulmonary diseases. He is the medical director of the Black Lung Clinic at Deaconess Hospital in Evansville, Indiana. He examined the claimant on August 1, 1989 and diagnosed pneumoconiosis due to dust exposure. He testified by deposition that claimant also suffers from chronic bronchitis and chronic obstructive pulmonary disease related to the effects of both coal mine employment and cigarette smoking. Dr. Houser's opinion was based on a physical examination, chest x-ray positive for pneumoconiosis, ventilatory studies showing a moderately severe obstructive disease, medical and employment histories as well as his review of the medical literature on the affect of coal dust on obstructive lung disease.

Dr. Ralph Kelly is claimant's treating physician. He noted black lung disease as a condition from which the claimant suffers. Dr. Kelly's diagnosis is given no credit as Dr. Kelly's qualifications are not in the record and the basis for the diagnosis is unknown.

Dr. Eisenstein, a pulmonary specialist, examined the claimant at the request of the Department of Labor on October 21, 1997. He diagnosed emphysema, asthma, cardiomyopathy with congestive heart failure and hypertension due to smoking and work environment. His report was based on a

[2]An eigth physician, Dr. Nelson, a pulmonary specialist, diagnosed clinical pneumoconiosis. He also diagnosed chronic bronchitis but did not address its etiology. DX 31.

physical examination, pulmonary function studies showing moderate obstructive lung disease and mild hypoxia and claimant's medical and employment histories.

Dr. Cohen, a pulmonary specialist, examined the claimant on June 2, 1998. Dr. Cohen diagnosed pneumoconiosis by chest x-ray as well as severe obstructive lung disease contributed to by cigarette smoking and coal dust exposure. His diagnosis is based on a physical examination showing respiratory distress after walking approximately 30 to 40 feet; a chest x-ray read as 1/0, positive for pneumoconiosis; pulmonary function tests demonstrating severe lung disease; medical history of shortness of breath since 1986 with steady decline until the year before his examination when claimant's condition deteriorated much more rapidly; and history of 17 years of coal mine employment and 32 years of cigarette smoking. Dr. Cohen reviewed the medical literature on whether obstructive lung disease can be caused by coal dust exposure and concluded that the literature, including a criteria document from NIOSH and at least seventeen studies of British and American coal miners, shows a positive link between an occupational exposure to coal dust and obstructive disease. A list of the studies were attached to his report.

Dr. Tuteur, a pulmonary specialist and an Associated Professor of Medicine at Washington University School of Medicine, examined the claimant on November 5, 1991. He diagnosed a cigarette-induced chronic bronchitis associated with a moderate obstructive ventilatory defect that improves following the administration of aerolized bronchodilator. Dr. Tuteur found the cause of claimant's condition to be cigarette smoking, but not associated with, aggravated by, or caused by the inhalation of coal dust. He saw no convincing data to support the diagnosis of pneumoconiosis. Dr. Tuteur's diagnosis was based on a physical examination showing breath sounds remarkably diminished, and associated with a prolongation of expiration; a chest x-ray consistent with emphysema but showing no interstitial changes consistent with coal workers' pneumoconiosis; pulmonary function tests revealing a moderate obstructive ventilatory defect that improves significantly following bronchodilator; and arterial blood gas results showing no impairment of gas exchange. On April 3, 1998 Dr. Tuteur conducted a second examination of the claimant. Dr. Tuteur again diagnosed chronic bronchitis due to smoking with some reversible component, unrelated to coal dust exposure. The testing on which he relied was very similar to his November 5, 1991 evaluation. The physical examination showed diminished breath sounds; chest x-ray and CT scan showed no interstitial process; pulmonary function tests revealing a moderate obstructive ventilatory defect that improves following bronchodilator; and arterial blood gas tests showing no impairment of gas exchange.

Dr. Tuteur subsequently conducted a review of medical data from the record. His review found a partially reversible moderate obstructive ventilatory defect not associated with a restrictive component. He interpreted his findings as typical of cigarette induced chronic obstructive pulmonary disease with its, in part, waxing and waning pattern. He reasoned that where coal workers' pneumoconiosis is sufficiently advanced to produce impairment, one does not find the degree of obstructive ventilatory defect present in claimant but rather a restrictive ventilatory defect.

Dr. Tuteur also testified by deposition on May 13, 1999. He re-iterated his earlier findings that the claimant suffers from a chronic obstructive pulmonary disease caused by smoking with no evidence of coal dust having a causative effect. He testified that his review of the medical literature shows that inhalation of coal mine dust can result in an obstructive defect but invariably such occurs when a person develops advanced coal worker's pneumoconiosis in the form of progressive massive fibrosis, and, in fact, when chronic obstructive pulmonary disease does occur with simple pneumoconiosis, it is associated with measurable though minimal airway obstruction, infrequent occurrence and small clinical significance.[3]

The medical evidence was also reviewed by Dr. Joseph Renn and Dr. Kirk Hippensteel. Both physicians are Board Certified in internal medicine and the subspecialty of pulmonary disease. Dr. Renn found that the claimant has chronic bronchitis with an asthmatic component and pulmonary emphysema as well as other ailments. He opined that claimant's pulmonary condition resulted from years of cigarette smoking rather than exposure to coal dust. Dr. Hippensteel diagnosed a variable, partially reversible obstructive lung disease associated with chronic cough that also contributes to shortness of breath. He observed that an asthmatic type of post bronchodilator improvement is not a feature of coal workers' pneumoconiosis but rather is explained by cigarette smoking. Dr. Hippensteel concluded that the claimant does not have evidence of pneumoconiosis and could not have industrial bronchitis so long after he left the mines.

It is determined that the medical opinion of Dr. Cohen as corroborated by the opinions of Drs. Houser and Eisenstein diagnosing legal pneumoconiosis should be credited. Dr. Cohen has extensive qualifications for rendering an opinion on the presence of legal pneumoconiosis. He is Assistant Professor of Health Policy Administration at the University of Illinois School of Public Health and an Assistant Professor of Medicine at the Rush University College of Medicine. He is also the Director of the Pulmonary Function and Cardiopulmonary Exercise Laboratory in the Division of Pulmonary and Occupational Medicine at Cook County Hospital in Chicago, Illinois. He evaluates and treats coal miners with respiratory problems at the hospital's Black Lung Clinic on behalf of the Department of Labor. He is also a consultant reviewer of the Black Lung Clinics Program with the U.S. Department of Health and Human Services and he has lectured extensively in the area of coal workers' pneumoconiosis. Dr. Houser is the Medical Director, Respiratory Therapy Department and Medical Director of School of Respiratory Therapy at Deaconess Hospital. His practice includes treatment of coal miners at Deaconess Hospital Black Lung Clinic. Treatment of coal miners constitutes about 20 to 25 percent of his practice.[4]

Drs. Renn and Hippensteel are well qualified as Board certified internists and pulmonologists, and Dr. Hippensteel is an Associate Professor of Medicine at the University of Virginia. Dr. Tuteur is

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[3]Deposition of Dr. Peter Tuteur, May 13, 1999; p. 27.

[4]Deposition of Dr. William Houser, September 30, 1992, p. 8.

also well qualified as the Director of the Pulmonary Function Laboratory, Washington University School of Medicine in St. Louis and has clinical duties including the treatment of patients for black lung disease in his medical practice. However, none have the extensive concentration on the treatment of black lung disease and administration of black lung treatment programs that is part of the combined experience of Drs. Cohen and Houser. Thus, their qualifications to present an opinion on coal dust as a cause of obstructive lung disease are considered superior to those of Drs. Tuteur, Renn and Hippensteel.

Dr. Tuteur testified that he found the cause of the claimant's pulmonary condition to be cigarette smoking without any influence from coal dust inhalation because his readings of chest x-rays revealed no evidence of pneumoconiosis, his physical examination demonstrates obstructive lung disease, and the physiologic testing fails to identify a restrictive ventilatory defect or significant persistent impairment of gas exchange.[5] Dr. Tuteur testified that in his opinion and based on his review of the literature, obstructive lung disease can result from coal dust inhalation but if obstructive lung disease occurs with simple pneumoconiosis, it is associated with only minimal airway obstruction.[6] Dr. Tuteur did not identify the literature on which he relied. Dr. Renn provided no reasoning for his conclusion that the etiology of his diagnosis of a moderate-moderately severe, significantly bronchoreversible, obstructive ventilatory defect was caused by cigarette smoking and could not have been caused or aggravated by coal dust inhalation. Dr. Hippensteel diagnosed a variable, partially reversible obstructive lung disease associated with chronic cough production that also contributes to shortness of breath. He opined that the claimant's coal dust exposure played no role in his pulmonary condition because the chest x-rays do not evidence pneumoconiosis; industrial bronchitis is eliminated as a cause because he left work in February of 1989 and industrial bronchitis would have subsided within a period of months after leaving exposure; claimant has normal diffusion and no evidence of restriction; significant smoking history; and partial reversibility indicating an asthmatic bronchitis component.

Dr. Cohen explained his finding of a coal dust etiology by reasoning that claimant's obstructive lung disease is consistent with both claimant's coal dust exposure and his cigarette smoking. He also expressed agreement with Dr. Houser that because claimant's past exposure to cigarette smoking was so distant, as claimant quit smoking in1973, before the onset of symptoms, it could hardly be a primary cause of his pulmonary condition. Dr. Cohen cited and explained in a supplemental consulting medical report dated April 19, 1999, the findings of medical and scientific studies that confirm the link between occupational exposure to coal dust and obstructive lung disease including a NIOSH criteria document which was used to support a 1995 NIOSH recommendation for reduced occupational exposure to respirable coal mine dust and studies showing miners without x-ray evidence of coal workers'

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[5]Id., p. 26.

[6]Id., p.27

pneumoconiosis having coal dust related pulmonary impairment.[7] Dr. Cohen also referenced a study which revealed the progressive nature of pneumoconiosis, as the study identified cases of pneumoconiosis discovered in miners who did not have the disease when they retired.

Dr. Houser's deposition testimony on the etiology of the claimant's obstructive lung disease corroborates the opinion of Dr. Cohen. Dr. Houser testified that the claimant has an obstructive lung disease related to two factors, working as a miner and prior cigarette smoking.[8] In support, Dr. Houser explained that medical literature is persuasive that coal mine dust exposure can cause chronic bronchitis which is obstructive in nature.[9]

Dr. Cohen also explained why he rejected asthma as the cause of the claimant's pulmonary condition. He observed that claimant's medical records show no indication of asthma, no diagnosis by a treating physician, no treatment for the condition, and spirometry showing only partial reversibility, still leaving claimant with a severe impairment of the FEV1.

In conclusion, Dr. Tuteur found no evidence of coal dust having a causative effect on the claimant's chronic obstructive pulmonary disease. In contrast, Drs. Cohen and Houser found significant medical evidence supporting coal dust as a causative factor. For the reasons explained above, the opinions of Drs. Cohen and Houser are credited because they are well reasoned, their qualifications to make them are superior and they are better supported by the medical literature. Claimant has shown the existence of legal pneumoconiosis under § 718.202(a)(4).

Total Disability pursuant to Section 718.204(c)(1)

The Board's remand requires reconsideration of the pulmonary function studies under § 718.204(c)(1). The September 17, 1999 Decision and Order found that the studies evidenced total pulmonary disability because all ten studies in the record yielded qualifying values under § 718.204(c)(1). However, the Board noted that eight of the studies included post-bronchodilator results which did not yield qualifying values and the Board required that those results be specifically considered. To interpret the effect of the post-bronchodilator results on the finding of total disability the opinions of the physicians of record on the pulmonary function test results are reviewed. Of the physicians who considered claimant's pulmonary function test results only Dr. Hippensteel found that the post-bronchodilator results indicate that the claimant could still work as a coal miner from a pulmonary standpoint. Dr. Houser observed moderate improvement after bronchodilator administration, but nevertheless testified by deposition that the claimant is totally disabled from a

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[7]Claimant's Exhibit 11

[8]Deposition of Dr. William Houser, September 30, 1992, pp. 17, 72

[9]Id. pp.27, 44, 50.

pulmonary condition. Dr. Eisenstein's pulmonary function testing did not include a post-bronchodilator test. He characterized claimant's pulmonary condition as a "major disability" and "major impairment." Dr. Kelly's treatment of the claimant included administering pre and post bronchodilator pulmonary function testing. Dr. Kelly found mild to moderate chronic obstructive pulmonary disease but he provided no opinion on whether the condition is totally disabling. Dr. Cohen's supplemental report of April 19, 1999 reviewed all the medical evidence of record. He interpreted the pulmonary function tests as showing a severe obstructive lung disease which deprives the claimant of the pulmonary capacity to return to coal mine employment. Dr. Cohen observed that the results of the August 1, 1989 test showed a good response to bronchodilators but that claimant still showed a moderate impairment even after bronchodilator therapy. Dr. Renn's report included a review of all the pulmonary function tests of record. He interpreted their results as showing a moderate-moderately severe ventilatory defect that significantly improved following inhaled bronchodilator, but was of a sufficient degree to prevent claimant from performing his coal mine employment.

Dr. Tuteur's opinion on whether claimant's pulmonary disability is totally disabling is equivocal. Dr. Tuteur's first report issued on November 5, 1991 included a pulmonary function test which he interpreted as showing a moderate obstructive ventilatory defect that improves significantly following bronchodilator therapy. He did not provide any opinion on whether the claimant was disabled. Dr. Tuteur's second report, dated April 3, 1998, is similar to his earlier report in that he again interpreted his pulmonary function test as showing a moderate obstructive ventilatory defect that improves following the administration of a bronchodilator, without providing an opinion on disability. Dr. Tuteur's April 12, 1999 report was a review of medical information of the claimant. He characterized the pulmonary function testing as demonstrating a partially reversible moderate obstructive ventilatory defect, and concluded that the claimant "is totally disabled from continuing work in the coal mines or work requiring similar effort." Although Dr. Tuteur does not confine his opinion on total disability to a pulmonary disability, such can be inferred in light of the subject of his evaluation being claimant's pulmonary condition. Dr. Tuteur testified by deposition on May 13, 1999. He testified that the "major characteristic" of the pulmonary function test results is "a moderate obstructive ventilatory defect unassociated with a restricted ventilatory defect[10]." On direct examination Dr. Tuteur testified that claimant's moderate obstructive ventilatory defect does not, in and of itself, preclude him from working;[11] however, on cross-examination, Dr. Tuteur answered no to the question of whether a person with claimant's pulmonary function could be a coal miner.[12] Considering the equivocation of Dr. Tuteur's opinion, it is not considered to be either supportive of, or contradictory to, a finding that the claimant's pulmonary function tests, with improvement after bronchodilator therapy, evidence a total pulmonary disability.

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[10] Deposition of Dr. Tuteur, May 13, 1999, p. 21, 22

[11] Id. p. 29

[12] Id. p. 38

Dr. Hippensteel reviewed the medical reports of record. He diagnosed obstructive lung disease. He offered no opinion on its severity except to state that claimant's "reversibility shows that with full bronchodilation he is not permanently impaired enough from a pulmonary standpoint to keep him from working at his previous job in the mines." The importance of Dr. Hippensteel's opinion is that the claimant cannot perform coal mine employment except under full brochodilation. What Dr. Hippensteel has in mind by work with full bronchodilation, and whether such is even possible, is not explained. In light of such ambiguity, it is determined that Dr. Hippensteel's report can not be considered as standing for the proposition that the claimant's pulmonary function studies do not qualify to evidence a total disability. Moreover, even if Dr. Hippensteel's opinion was considered as unequivocal on whether the pulmonary function tests should be considered as qualifying it would be contrary to the preponderance of the physicians' opinions.

Thus, the opinions of the physicians who reviewed the pulmonary function tests support a finding that those tests demonstrate a finding of total disability under § 718.204(c)(1), notwithstanding the non-qualifying results of the post-bronchodilator tests.

Total Disability pursuant to Section 718.204(c)(4)

The September 17, 1999 Decision and Order determined that the weight of the medical opinion evidence supports a finding of a total pulmonary disability under § 718.204(c)(4). The opinions of Drs. Houser, Cohen and Renn were considered to be deserving of the most weight as they are consistent with and supported by the qualifying pulmonary studies. The Board required that this finding be reconsidered because the non-qualifying post-bronchodilator pulmonary function tests were not considered.

As explained in the discussion on total disability under § 718.204(c)(1), *supra*, the pulmonary function tests do support a finding that the claimant is totally disabled from a pulmonary condition, and thus support the opinions of those physicians finding a total pulmonary disability. Moreover, for the reasons set forth, *supra*, the physicians' opinions finding a total pulmonary disability are entitled to dispositive weight. Only the opinion of Dr. Hippensteel can be interpreted reasonably as finding that claimant is not totally disabled from a pulmonary problem, and his opinion conditions the finding on the claimant doing his last coal mine job "with full bronchodilation." Thus the weight of the medical reports show that the claimant's pulmonary condition is totally disabling.

It is clear, after a review of all the medical evidence, like and unlike, particularly the physicians' reports finding a total pulmonary disability and the pulmonary function test results showing same, as well as a consideration of the blood gas tests which do not reveal a problem of gas exchange, that claimant's pulmonary condition is totally disabling. None of the physicians who presented an opinion on the claimant's pulmonary condition found that he could not be disabled because the arterial blood gas tests do not reveal a problem with gas exchange.

Causation

The September 17, 1999 Decision and Order found that the claimant's total pulmonary disability was caused at least in part by pneumoconiosis. The finding was based primarily on the opinions of Drs. Cohen and Houser being the best reasoned in the record. The Board held that giving dispositive credit to Drs. Cohen and Houser was permissible, but since the findings of the existence of pneumoconiosis and the existence of a total pulmonary disability were remanded for reconsideration, the Board held that the findings on causation must also be vacated.

As explained herein, *supra*, the evidence reveals the existence of pneumoconiosis and the presence of a totally disabling pulmonary condition. Thus, the findings by Drs. Cohen and Houser that the total pulmonary disability is caused by pneumoconiosis are reinstated because their opinions on causation are the best reasoned in the record. They are consistent with the x-ray evidence of record showing clinical pneumoconiosis and the medical evidence showing that the claimant's totally disabling chronic obstructive pulmonary disease is caused at least in part by coal dust exposure. See discussion at § 718.202(a)(4), *supra*, for the reasoning for the finding that claimant's pulmonary condition is caused by both his coal dust exposure and his cigarette smoking.

The Board's remand ordered reconsideration of Employer's Exhibits 16-19, documents filed with the Illinois Industrial Commission. Employer offered the documents to show a pre-existing disability from a knee injury and thus that claimant is not eligible for black lung benefits because of a pre-existing total disability under the holding of *Peabody Coal Co. v. Vigna*, 22 F. 3d 1388, (7th Cir. 1994). As previously explained, the Department of Labor's recent amendments to its black lung regulations in effect abrogated the Court's decision in *Peabody*. Moreover, the aforesaid records of the Industrial Commission do not establish a total disability from a knee injury as they do not show that claimant could not work with the knee injury.

Commencement of Benefits

Benefits are payable commencing on the date that the claimant became totally disabled due to pneumoconiosis, or if such a date can not be determined from the record, the month in which the claimant filed his present claim, which is September, 1997. 20 C.F.R. § 725.503. The September 17, 1999 Decision and Order found benefits to be payable from September of 1992, the month in which Dr. Houser provided deposition testimony that the claimant is totally disabled due to pneumoconiosis. The Board vacated the finding and ordered that the date be reconsidered in light of the non-qualifying post-bronchodilator pulmonary function tests and blood gas tests taken subsequent to Dr. Houser's deposition.

Claimant is correct when he argues in his brief that the date for determining the onset of the

disease is not the date when Dr. Houser testified to the existence of the pulmonary disability but the date on which his examination established its presence, August 1, 1989. Although Dr. Houser's report of that examination was silent as to total disability his subsequent deposition testimony expanded on the report by diagnosing claimant's condition as totally disabling.

The August 1, 1989 examination of the claimant by Dr. Houser included qualifying ventilatory studies, an x-ray interpreted as positive by two physicians who are board certified radiologists, and symptoms of bronchitis and moderate obstructive lung disease, all of which Dr. Houser found in his subsequent deposition testimony to be indicative of totally disabling pneumoconiosis. The post-bronchodilator pulmonary function tests and the arterial blood gas tests taken after Dr. Hauser's examination do not negate the August 1, 1989 finding as the preponderance of the reports by the physicians who reviewed those test found that claimant is totally disabled from a pulmonary problem. See discussion of Section 718.204(c)(4), *supra*.

Accordingly, benefits are payable as of August, 1989.

ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein because no application has been received from Counsel. A period of thirty (30) days is hereby allowed for Claimant's Counsel to submit an application. The application must conform to 20 C.F.R. § 725.365 and § 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and the Solicitor, as Counsel for the Director. Parties so served have ten (10) days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

IT IS HEREBY ORDERED that the Employer, Peabody Coal Company, shall pay to claimant all benefits to which he is entitled under the Act, commencing on August 1, 1989.

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THOMAS M. BURKE
Associate Chief Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.